



School Blanket Professional Liability Insurance Application

Program Offered Through: HPSO
159 East County Line Road • Hatboro, PA 19040-1218
Phone: 1-800-986-4627 • Fax: 1-866-321-0905

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1. Application Information

PLEASE COMPLETE THE FOLLOWING:

- Name of School: _____
- Street Address: _____
City: _____
State: _____ Zip: _____
- Person to contact at school:
 - Title: _____
 - Department: _____
 - Telephone: _____
 - Fax: _____
 - E-Mail: _____
- Requested Effective Date of Policy: _____ / _____ / _____
MONTH DAY YEAR
- Are you a member of a professional association? Yes No
Name of association(s): _____
- If you have a current policy, please list the expiration date:
_____ / _____ / _____
MONTH DAY YEAR
- Is your policy claims made? Yes No
- Please list your current carrier: _____
- Have any claims been made against a student, faculty member or the school for incidents in the providing of or failure to provide professional services in the past? Yes No
(If "Yes," please provide complete details on a separate sheet of paper and attach to application.)
- Have you ever had professional liability insurance declined, canceled or non-renewed for any reason other than for non-payment of premium?
Not applicable for MO residents. Yes No
- Is your school: Accredited Non-accredited?
- How long has your school been in existence? _____

Insurance Agent: Michael J. Loughran Iowa License #IA241616; Florida License #A158896

2. Choose Your Plan

	Plan A \$1MM/\$5MM	<input type="checkbox"/>	STUDENTS \$13 Each Student	FACULTY Included	SCHOOL Included	NUMBER OF STUDENTS _____ X \$13	MEMBERSHIP FEE* + \$10	TOTAL ESTIMATED AMOUNT = _____
	Plan B \$2MM/\$5MM	<input type="checkbox"/>	STUDENTS \$16 Each Student	FACULTY Included	SCHOOL Included	NUMBER OF STUDENTS _____ X \$16	MEMBERSHIP FEE* + \$10	TOTAL ESTIMATED AMOUNT = _____

Your school may be eligible for a discount. Note: minimum premium for an annual period is \$300.00

Discount information to be completed by HPSO.
We will review your application for appropriate discount opportunities.

Please see last page of application for compensation disclosure information.

Continue to next page of Application ➔

*All Applicants must add a Healthcare Providers Service Organization Purchasing Group Membership Fee of \$10.00 for School Institutions. Please see last page of application for compensation disclosure information.



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3. Area of Practice

Name of School _____

Please estimate the number of students from the Healthcare Specialties listed below to be enrolled during the policy period. If there is more than one session, please indicate the total number of students for all sessions.

Art Therapist	_____	Enterostomal Therapist	_____	Occupational Therapist	_____
Athletic Trainer	_____	Exercise Physiologist	_____	Occupational Therapist Asst	_____
Audiologist	_____	Gerontology	_____	Optometry Tech/Asst	_____
Bio-Med Tech	_____	Health Care / Services Admin	_____	Orthopedic Asst	_____
Blood Bank Tech	_____	Health Educator	_____	Patient Care Technician	_____
Certified Lab Tech	_____	Histologic Tech	_____	Pedorthist	_____
Certified Medical Asst	_____	Hospital Pharmacy Tech	_____	Perfusionist	_____
Certified Medical Aid	_____	Kinesiologist/	_____	Pharmacist	_____
Chiropractic Asst	_____	Kinesiotherapist	_____	Pharmacist Asst/Tech	_____
Circulation Tech	_____	Laboratory Aide	_____	Phlebotomist	_____
Clinical Lab Tech	_____	Laboratory Tech	_____	Physical Therapist	_____
Community Health Asst	_____	Massage Therapist	_____	Physical Therapist Asst	_____
Community Health Tech	_____	Medical Assistant	_____	Podiatric Asst	_____
Corrective Therapist	_____	Medical Lab Tech	_____	Psychological Counselor	_____
Counselor		Medical Tech	_____	Radiation Therapist	_____
Alcohol/Drug	_____	Medical Tech Asst	_____	Radiologic Tech	_____
Marriage/Family	_____	Medical Records	_____	Recreation Therapist	_____
Pastoral	_____	Administrator	_____	Rehabilitation Asst	_____
Personnel and/		Medical Records Tech	_____	Rehabilitation Therapist	_____
or Guidance	_____	Mental Retardation Work	_____	Renal Dialysis Tech	_____
School	_____	Medical Technologist	_____	Social Worker	_____
Wellness	_____	Medical Preparation Tech	_____	Speech Hearing Therapist	_____
Clinical/Rehab/		Music Therapist	_____	Speech Language Pathologist	_____
Mental Health	_____	Nuclear Medical Tech	_____	Sports Medicine Instructor	_____
Dance Therapist	_____	Nurse		Sports Medicine Therapist	_____
Dental Asst	_____	RN	_____	Surgical Assistants	_____
Dental Hygienist	_____	Home Health Aide	_____	X-Ray Machine Operator	_____
Dental Lab Tech	_____	LPN/LVN	_____		
Diagnostic Medical	_____	Nurse's Aide	_____		
Sonographer	_____	Nursing Asst	_____		
Dialysis Tech	_____	Geriatric Nursing Asst	_____		
Dietitian	_____	Nurse Practitioner			
EEG Tech	_____	Geriatric/Adult or	_____		
EKG Tech	_____	Family Planning - GYN	_____		
Electrologist	_____	Psychiatric	_____		
EMS - Paramedic	_____	Pediatric/Family Practice	_____		
EMS - Basic/Intermediate	_____	/Neonatal	_____		
EMS - Volunteer	_____	OB/GYN	_____		
EMS - First Responder	_____	Nutritionist	_____		

OTHER:
Please use the following space if you need coverage for any students whose specialty is not listed above.
NOTE: You must include the number of students for each specialty listed.



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4. Agreement

Name of School: _____

I have answered the questions in the application to the best of my ability, and declare that to the best of my knowledge, the statements set forth herein are true and correct. I have not withheld information that would influence the judgment of the Insurance Company. My signing of the application does not bind the Insurance Company to complete the insurance, but it is agreed that this application shall be the basis of the contract should a policy be issued. I agree that this application, a copy of which will be attached to the proposed policy, and any materials submitted or required (which shall be maintained on file by the Insurance Company and be deemed attached as if physically attached to the proposed policy), are true and are the basis of the proposed policy and are to be considered as incorporated into and constituting a part of the proposed policy. I have read and consent to the compensation terms below.

This program is not available to students training to be physicians, dentists, nurse anesthetists, nurse midwives, chiropractors, or podiatrists. Also, you are not covered for the administration or the operation of motor-driven vehicles.

FRAUD NOTICE - WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may be subject to civil fines and criminal penalties (For District of Columbia residents only: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.) (For Florida residents only: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.) (For Louisiana residents only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.) (For Maine residents only: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.) (for New York residents only: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) (For Pennsylvania residents only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.) (For Tennessee and Washington residents only: Penalties include imprisonment, fines and denial of insurance benefits.) (For Vermont residents only: any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may be subject to civil fines and criminal penalties.)

5. Signature

SIGNATURE X _____ DATE ____/____/____
ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED IN INK.

This program is underwritten by American Casualty Company of Reading, Pennsylvania, a CNA company and is offered through the Healthcare Providers Service Organization Purchasing Group. All products and services may not be available in all states and may be subject to change without notice. CNA is a service mark and trade name registered with the US. Patent and Trademark Office.

Healthcare Providers Service Organization is a division of Affinity Insurance Services, Inc.; in CA (License #0795465), MN & OK, AIS Affinity Insurance Agency, Inc.; and in NY, AIS Affinity Insurance Agency.

COMPENSATION and OTHER DISCLOSURE INFORMATION

Healthcare Providers Service Organization (HPSO), a division of Affinity Insurance Services, Inc., exclusively offers the HPSO Program as an agent of CNA and provides services that may include the following: program marketing, underwriting, policy management, risk management and client services on its behalf.

As compensation for the services described above, Affinity receives 20% of your paid premium as commission for marketing the program and 20% for underwriting, policy management, billing, risk management and client services. For mid-term premium bearing coverage endorsements and renewal policies, Affinity is compensated at the same levels as the initial policy commission, unless we notify you otherwise.

Other than the commissions described in the preceding paragraph, Affinity will receive no other compensation from the insurer. However, Affinity may charge a Healthcare Providers Service Organization Purchasing Group Membership fee.

Your signature on your application, quote form, check and/or other authorization for payment of your premium, will be deemed to signify your consent to and acceptance of the terms and conditions including the compensation, as disclosed above, that is to be received by Affinity.

In addition, premiums paid by Clients to Affinity for remittance to insurers, Client refunds and claim payments paid to Affinity by insurance companies for remittance to Clients are deposited into fiduciary accounts in accordance with applicable insurance laws until they are due to be paid to the insurance company or Client. Subject to such laws and the applicable insurance company's consent, where required, Affinity will retain the interest or investment income earned while such funds are on deposit in such accounts.

Aon Corporation, our ultimate parent company, and its affiliates have from time to time sponsored and invested in insurance and reinsurance companies. While we generally undertake such activities with a view to creating an orderly flow of capacity for our clients, we also seek an appropriate return on our investment. These investments, for which Aon is generally at-risk for potential price loss, typically are small and range from fixed-income to common stock transactions. In such case, the gains or losses we make through your investments could potentially be linked, in part, to the results of treaties or policies transacted with you. Please visit the Aon website at http://www.aon.com/market_relationships for a current listing of insurance and reinsurance carriers in which Aon Corporate and its affiliates hold any ownership interest.

Contracts and Agreements

Aon Corporation's operating affiliates are parties to numerous agreements with many insurance and reinsurance companies, including companies from which our clients have purchased insurance or reinsurance. Please visit http://www.aon.com/market_relationships for more detail on these agreements.